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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD STEVEN POCCIA** **1405 Meek Avenue** **Napa, CA 94559** **Registered Nurse License No. RN 397687** Respondent.	Case No. 2010 - 644 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 13, 1986, the Board of Registered Nursing issued Registered Nurse License Number RN 397687 to Richard Steven Poccia (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY AND REGULATORY PROVISIONS

4. Section **822** of the Code states:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

5. Section **2750** of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section **2764** of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

7. Section **2761** of the Code states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct . . . .

. . .

8. Section **2762** of the Code states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

DANGEROUS DRUG/CONTROLLED SUBSTANCES

9. Section **4021** of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

10. Section **4022** of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use, except veterinary drugs that are labeled as such, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

11. **Fentanyl** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(8) and is a dangerous drug per Business and Professions Code Section

4022. Fentanyl is a narcotic analgesic that is used to treat pain.

12. **Hydromorphone**, also known as **Dilaudid**, is a narcotic pain reliever and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

13. **Klonopin** is a brand name for the drug **Clonazepam**, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(7) and a controlled substance pursuant to Business and Professions Code Section 4022. It is used to treat seizure and panic disorders.

14. **Lorazepam** is the generic name for **Ativan**, a Schedule IV controlled substance as listed in Health and Safety Code section 11057 (d)(16) and is a dangerous drug per Business and Professions Code section 4022, intended for the treatment of anxiety or depression.

15. **Methadone**, a narcotic pain reliever, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(14), and a dangerous drug per Business and Professions Code section 4022.

16. **Morphine**, a narcotic pain reliever, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug per Business and Professions Code section 4022.

17. **Tylenol #4**, a narcotic pain reliever containing a combination of acetaminophen and codeine, is a Schedule III controlled substance as designated by Health and Safety Code Section 11056, and a dangerous drug per Business and Professions Code section 4022.

COSTS

18. Section **125.3** of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FACTUAL SUMMARY

California Pacific Medical Center

19. From on or about June, 2004, until August, 2008, Respondent worked as a registered nurse at California Pacific Medical Center (hereinafter "CPMC") in San Francisco, California. Respondent worked at the Davies Campus and the Pacific Campus. He had access to the Pyxis[1] at both campuses.

20. During his employment at CPMC during 2008, Respondent made numerous medication withdrawals from the Pyxis without a physician's order and/or without adequately documenting the disposition of the medication. Respondent made withdrawals at times when he was not working at CPMC.

21. A review of the Pyxis system revealed numerous discrepancies including, but not limited to:

Patient A:

22. On August 3, 2008, at 10:00 hours, Patient A's physician ordered Hydromorphone HCL Tab 2mg, #1, PO, Q4H, PRN pain. At 22:48 hours, Patient A's physician also ordered (Ativan) Lorazepam Inj (2 mg/ml) 2mg, IV, Q2h-ODD.

23. On August 3, 2008, at 18:48 hours, Respondent withdrew Hydromorphone 2mg injectable from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order in place for injectable Hydromorphone.

24. On August 3, 2008, at 21:44 hours, Respondent withdrew Hydromorphone 2mg injectable from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order in place for injectable Hydromorphone.

25. On August 3, 2008, at 22:56 hours, Respondent withdrew a Lorazepam syringe from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

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[1] The Pyxis is an automated drug dispensing system which is used to account for withdrawals of medications for administration to patients.

Patient B:

26. On August 3, 2008, at 14:04 hours, Respondent withdrew a 4 mg syringe of Hydromorphone from the Pyxis for Patient B but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient B. Respondent's shift at CPMC did not start until 56 minutes after this withdrawal occurred.

Patient C:

27. On August 1, 2008, at 13:22 hours, Respondent withdrew a 4 mg syringe of Hydromorphone from the Pyxis for Patient C but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient C. Respondent's shift at CPMC did not start until approximately 90 minutes after this withdrawal occurred. At 13:50 hours, Patient C was discharged from CPMC with no complaints of pain.

Patient D:

28. On July 7, 2008, at 18:21 hours, Patient D's physician ordered (Tylenol #4) Acetaminophen 30 mg/Codeine Phosphate 60 mg tab, #2, PO, Q6 H PRN Pain.

29. On August 1, 2008, at 22:24 hours, Respondent removed Tylenol #4, 2 tabs, from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

30. On August 1, 2008, at 21:25 hours, Respondent removed Methadone 10 mg, 2 tabs, from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient D.

Patient E:

31. On July 12, 2008, at 13:11 hours, Respondent removed Hydromorphone 2 mg injectable from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient E. Respondent was assigned to work on a different CPMC campus on this day, and his shift did not start until later in the day.

Patient F:

32. On June 13, 2008, at 14:00 hours, Respondent removed Hydromorphone 2 mg injectable from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient F.

33. On June 26, 2008, at 10:14 hours, Respondent removed Hydromorphone 2 mg injectable from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient F.

Patient G:

34. On July 8, 2008, at 24:00 hours, Patient G's physician ordered Morphine Sulphate Inj (4 mg/ml) 4 mg, IV, Q1H, PRN Pain. Patient G's physician also ordered (Klonopin) Clonazepam Tab 0.5mg, #1, PO, QHS, PRN Insomnia.

35. On July 12, 2008, at 16:02 hours, Respondent removed Morphine, 2mg syringe from the Pyxis and charted administration of the medication at 16:10 hours, noting that the patient had no relief from PO Dilaudid. There was, however, no physician's order for administration of Dilaudid to this patient.

36. On July 12, 2008, at 16:36 hours, Respondent removed Hydromorphone, 1 mg/1ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient G.

37. On July 12, 2008, at 19:20 hours, Respondent removed Morphine, 4 mg syringe, from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

38. On July 12, 2008, at 20:15 hours, Respondent removed Hydromorphone, 2 Mg Inj, from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition. There was no physician's order for the administration of this medication to Patient G.

39. On July 12, 2008, at 20:39 hours, Respondent removed two Clozanepam, .50 mg tablets from the Pyxis. At 22:00 hours Respondent documented the administration of one tablet, but failed to chart administration of the other tablet or otherwise account for its disposition.

Novato Community Hospital

40. From on or about September, 2008, until February, 2009, Respondent worked as a registered nurse at Novato Community Hospital (hereinafter "NCH") in Novato, California. During this time, Respondent had access to the Pyxis.

41. During his employment at NCH during February, 2009, Respondent made numerous medication withdrawals from the Pyxis without adequately documenting the disposition of the medication.

42. A review of the Pyxis system revealed numerous discrepancies including, but not limited to:

Patient A:

43. On January 31, 2009, Patient A's physician prescribed Hydromorphone 1 mg/ml syringe every 1 hour as needed for pain.

44. On February 2, 2009, at 12:56 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

Patient B:

45. On February 9, 2009, patient B's physician prescribed Hydromorphone 1 mg/ml syringe every 1 hour as needed for pain.

46. On February 10, 2009, at 06:40 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

47. On February 10, 2009, at 16:10 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

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Patient C:

48. On February 2, 2009, Patient C's physician prescribed Lorazepam 1 mg Tab every four hours as needed.

49. On February 10, 2009, at 07:06 hours, Respondent removed one Lorazepam 1 mg tab from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

Patient D:

50. On February 17, 2009, Patient D's physician ordered morphine 10 mg/ml syringe 5 mg interaven every two hours as needed.

51. On February 18, 2009, Respondent removed one 10 mg/ml syringe of morphine from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

Patient E:

52. On February 11, 2009, Patient E's physician prescribed Hydromorphone 1 mg/ml syringe every 1 hour as needed for pain.

53. On February 18, 2009, at 09:03 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

54. On February 18, 2009, at 13:08 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

55. On February 18, 2009, at 16:04 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

Patient G:

56. On February 18, 2009, Patient G's physician prescribed Fentanyl, 0.05 mg/ml syringe 50 mcg intraven every one hour as needed.

57. On February 19, 2009, at 08:46 hours, Respondent removed one 100 mcg 2 ml

Fentanyl syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

58. On February 19, 2009, at 10:42 hours, Respondent removed one 100 mcg 2 ml Fentanyl syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

59. On February 19, 2009, at 13:23 hours, Respondent removed one 100 mcg 2 ml Fentanyl syringe from the Pyxis and noted administration of 5 mcg to Patient G, but failed to chart administration of the remainder of the medication or otherwise account for its disposition.

60. On February 19, 2009, at 18:28 hours, Respondent removed one 100 mcg 2 ml Fentanyl syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

61. On February 19, 2009, at 19:48 hours, Respondent removed one 100 mcg 2 ml Fentanyl syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

Patient H:

62. On February 20, 2009, Patient H's physician prescribed Hydromorphone 1 mg/ml syringe every 1 hour as needed for pain.

63. On February 21, 2009, at 08:00 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

64. On February 21, 2009, at 07:39 hours, Respondent removed one Hydromorphone 1 mg/ml syringe from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

65. Respondent is subject to disciplinary action under section 2761(a) of the Code in that he acted unprofessionally, as set forth above in paragraphs 19-64.

SECOND CAUSE FOR DISCIPLINE

(False, Incorrect, Inconsistent or Unintelligible Charting)

66. Respondent is subject to disciplinary action under sections 2761 and 2762(e) of the Code in that he falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to controlled substances/dangerous drugs, as set forth above in paragraphs 19-64.

THIRD CAUSE FOR DISCIPLINE

(Unlawfully Obtaining Dangerous Drugs/Controlled Substances)

67. Respondent is subject to disciplinary action under sections 2761 and 2762(a) of the Code in that he obtained and possessed, in violation of law and in the absence of a valid prescription, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022, as set forth above in paragraphs 19-39.

FOURTH CAUSE FOR DISCIPLINE

(Mental or Physical Illness Affecting Competency)

68. Respondent is subject to disciplinary action under section 822 of the Code in that he is mentally ill, or physically ill affecting competency. The circumstances are as follows:

69. On or about March 26, 2010, Respondent informed the Board's investigator that he was on disability. Respondent stated that he suffers from Post Traumatic Stress Disorder and depression and that he should not be working as a nurse, and that he may have suffered a stroke.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 397687, issued to Richard Steven Poccia;

2. Ordering Richard Steven Poccia to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/17/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant